

December 3, 2010

Michael Gelder
Senior Health Policy Advisor to Governor Pat Quinn
Chair, Illinois Health Care Reform Implementation Council
Via email to: gov.healthcarereform@illinois.gov

Dear Mr. Gelder:

I am writing in response to the request by the Health Care Implementation Council for **comments regarding insurance exchanges.**

At today's hearing for the House Special Committee on Medicaid Reform, the Director of the Department of Health and Family Services described the state's work on eligibility, verification and enrollment processes needed now and as coverage expands under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (ACA) in 2014. As an advocate and service provider for people who will likely become newly eligible for insurance in 2014, I appreciate the state's attention to creating simple, navigable, expeditious systems for enrollment. I also appreciate the attention paid to creating continuity between Medicaid and insurance exchange plans as people of modest incomes will likely cross and re-cross income eligibility thresholds over years of participation.

At this time, I would like to call the Council's attention to the specific insurance exchange enrollment challenges facing people returning to the community from jails and prisons and to the benefits attained through comprehensive enrollment prior to release.

First, people under correctional supervision in Illinois prisons and jails have disproportionately high rates of chronic diseases, including mental health and substance use disorders. They are also largely poor and uninsured. Illinois has invested in a significant infrastructure to provide appropriate care, including community medical and mental health centers and publicly funded substance abuse treatment – both in the community and inside correctional facilities. However, funding limits have meant that most people in need of treatment have not gotten it. More often, people receive acute care in emergency rooms and correctional facilities but without the chronic care management and ongoing treatment required to resolve these conditions and reduce public expenditures. For those who receive it, treatment in jail or prison can begin the process of recovery, but continued services in the community are necessary for recovery to be sustained.ⁱ

Second, there are numerous potential barriers to enrollment for this population. One significant barrier to enrollment is that, at the time of arrest, people do not necessarily have with them the identification and documentation necessary for Medicaid enrollment. Additionally, Medicaid

enrollment will need to be simplified and expedited, as many detainees have substance use and psychiatric disorders that interfere with their ability to make healthful choices toward recovery and rehabilitation. Unfamiliar insurance enrollment and eligibility maintenance procedures will present significant and unexpected barriers to accessing and engaging in health care services.

Additional barriers to Medicaid enrollment were identified by a Kaiser Family Foundation surveyⁱⁱ of Medicaid directors in states with program expansions that include childless adults. Barriers included the lack of awareness among the newly eligible population and difficulty communicating with them through conventional public messaging strategies. The directors surveyed described effective outreach strategies that addressed these problems, including the utilization of primary and specialty community health providers as enrollment sites. Additionally, an evaluation of the Massachusetts's universal insurance program identified subgroups of eligible people who did not enroll in publicly funded plans or were only episodically insured. Lack of enrollment was often caused by a failure to complete enrollment forms, a problem that escalated as the number of people covered who had active substance use disorders increased. Periodic incarceration also exacerbated the situation, as Medicaid eligibility ceased during confinement and a cumbersome reenrollment process was required following release.ⁱⁱⁱ

Third, we see opportunity for the state to expedite enrollment as part of its effort to contain costs. Under ACA, in 2014 most of men and women incarcerated in jails and prisons will be eligible for health care coverage, or for their coverage to resume, when they return to the community. To best contain costs, it is imperative that people with substance abuse, mental health and other chronic conditions begin or resume care immediately upon returning to the community. **Thus the goal should be to complete enrollment in Medicaid or private insurance prior to leaving the facility. Eligibility for billing would the day the person leaves the facility.**

Practically speaking, the criminal justice system can and should be an active partner in enrollment. As a mechanism for enrolling new Medicaid patients, jail and prison personnel may be assigned to enrollment, or the state may contract with community providers to handle enrollment. For example, after the District of Columbia expanded health care to include childless adults, the jail system developed a protocol with the District Medicaid authority by which all detainees are automatically enrolled during their detention. Individuals receive Medicaid cards with their personal property at release,^{iv} enabling access to and continuity in community-based care.

Further, we recommend that the use of electronic records to expedite enrollment be explored, similar to the approach the state is considering of using Department of Revenue records to verify income eligibility. A high-tech option for enrollment technology would be for the correctional systems' information system and the state Medicaid and insurance enrollment data systems to connect. This would help (1) identify detainees who are *not* currently enrolled in Medicaid or

insurance and (2) automatically enroll them while incarcerated, so they would leave with a valid Medicaid card.

Thank you for the opportunity to provide comments regarding the health exchanges.

Sincerely,

Pamela F. Rodriguez
President & CEO

References:

ⁱⁱ National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.

ⁱⁱ Kaiser Commission on Medicaid and the Uninsured. *Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences*. Washington: Henry J. Kaiser Family Foundation, 2010.

ⁱⁱⁱ National Association of State Alcohol and Drug Abuse Directors, *The Effects of Health Care Reform on Access to, and Funding of, Substance Abuse Services in Maine, Massachusetts, and Vermont*. Washington: The National Association of State Alcohol and Drug Abuse Directors, 2010.

^{iv} Steve Rosenberg, telephone conversation, 14 July 2010.